

November 2009

The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage

– Stan Dorn, J.D., Ian Hill, M.P.A., M.S.W., Sara Hogan, M.H.S.

SUMMARY

Less than two years after Massachusetts' 2006 reform law went into effect, only 2.6 percent of residents were uninsured¹—the lowest proportion ever recorded in an American state. Fully 56 percent of the state's increase in coverage took place through Medicaid and Commonwealth Care (CommCare), the state's new subsidy program for uninsured adults with incomes at or below 300 percent of the Federal Poverty Level (FPL).

By itself, the state's well-known individual mandate does not explain this result, since it is not enforced against adults with incomes at or below 150 percent FPL and does not apply to children. And while Massachusetts generously subsidizes low-income residents to enroll in comprehensive coverage, the same is true of many other programs that have reached a much smaller proportion of eligible, low-income consumers.

Interviews with policymakers, stakeholders, advocates, and others, as well as a review of published reports, indicate that a number of factors contributed to Massachusetts' high enrollment levels. Particularly important were the use of data, rather than traditional application forms, to establish subsidy eligibility for roughly a quarter of all newly insured residents; and an integrated system that serves multiple subsidy programs with a single application form and eligibility determination process. Through that system, more than half of all applications are completed and filed on-line by health care providers and community-based organizations acting on behalf of consumers, rather than by the consumers themselves.

OVERVIEW OF MASSACHUSETTS' REFORM

Massachusetts' health reform legislation was signed into law in April 2006. For purposes of this report, the key parts of the reform include coverage subsidies for consumers, an individual mandate to purchase insurance, and regulations surrounding uncompensated care and reimbursement to providers.

Subsidies

A new subsidy program, Commonwealth Care (CommCare), provides comprehensive benefits to adults who are ineligible for Medicaid and whose incomes fall below 300 percent of the federal poverty level (FPL), with premiums based on income. The program is administered by a newly-created, independent state agency called the Commonwealth

Health Insurance Connector Authority (the “Connector”). In addition to establishing CommCare, the reform legislation extends Medicaid coverage for children up to 300 percent FPL.

Individual mandate

Under the 2006 legislation, adults who can afford health insurance are legally required to purchase it. This mandate applies through the state income tax system, but it is not enforced against adults with incomes at or below 150 percent FPL, and children are exempt.

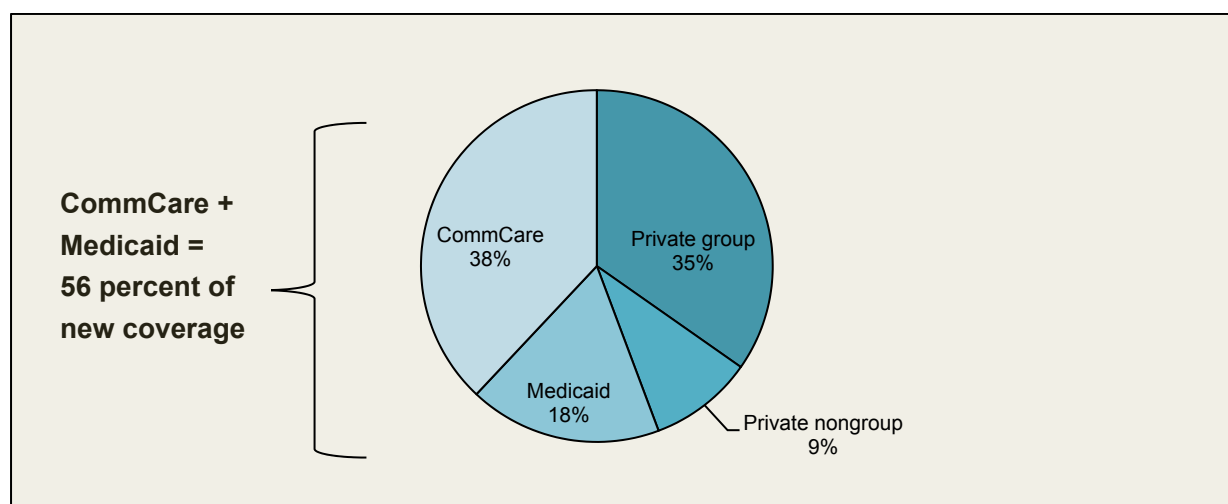
Uncompensated care

Before the 2006 reform, uncompensated care was reimbursed by the Uncompensated Care Pool (UCP), which has been replaced by the Health Safety Net (HSN). The HSN continues to pay hospitals and community health centers for uncompensated care, but it maintains stricter limits than the UCP, since reform legislation has lowered uncompensated care costs.

CHANGES IN MASSACHUSETTS INSURANCE COVERAGE SINCE 2006 LEGISLATION

Between 2006 and 2008, the proportion of state residents without insurance coverage fell from 6.4 percent to 2.6 percent.¹ More than half of this increase in coverage (56 percent) took place through Medicaid and CommCare (Figure 1). Since the end of 2007, CommCare enrollment has been the single largest contributor to the state’s increase in health coverage.

Figure 1. Net increase in the number of Massachusetts residents with health insurance, by coverage type: June 30, 2006, to December 31, 2008



Source: Authors' calculations, Massachusetts Division of Health Care Finance and Policy, May 2009.

RESEARCH METHODOLOGY

To learn more about Massachusetts' implementation of health care reform and to investigate how the state succeeded in enrolling so many low-income uninsured into subsidized coverage, evaluators conducted a site visit to Boston in

¹ Division of Health Care Finance and Policy. 2009. Health Care in Massachusetts: Key Indicators: May 2009. Boston, MA.

July 2009. During the site visit, evaluators met with more than 15 key informants representing a broad range of perspectives, including the Medicaid and Commonwealth Care programs, public and private providers (primarily hospitals and community health centers), health plan administrators, health care advocates, health policy researchers, and community-based outreach agencies. All interviews were conducted using structured protocols by evaluation team members from the Urban Institute. To supplement information gathered during the site visit, the research team also drew upon a range of published reports and analyses of the state's programs.

WHAT WORKED?

Several factors contributed to high participation levels in Massachusetts' health care programs while lowering administrative costs. These factors include the use of data, rather than traditional application forms, to establish eligibility, whenever possible; an integrated eligibility system serving multiple subsidy programs with a single application form; the aggressive use of health care providers and community-based organizations to file applications on behalf of consumers; and an intensive public education campaign.

Data-driven eligibility and automatic enrollment into CommCare

When data from the UCP showed that uninsured adults qualified for CommCare, they were automatically "converted" to CommCare coverage, without any need to submit new applications. By June 2007 (eight months into the new program), such "auto-converted" members represented more than 80 percent of CommCare participants. By December 2007, former UCP enrollees, most of whom were presumably auto-converted to CommCare, numbered nearly 100,000 out of 158,000 CommCare members, or roughly a quarter of all newly insured residents.²

An integrated system that uses information technology to seamlessly determine eligibility for multiple health subsidy programs

A single application is used for Medicaid (which, in Massachusetts, includes the Children's Health Insurance Program, or "CHIP"), CommCare, the HSN, and a state-funded program for certain low-income, immigrant children. The form is processed by a single statewide unit within the Medicaid agency, using automated procedures to determine eligibility. As a result, consumers submit just one application to learn the program through which they qualify for coverage (if any); consumers need not go from one agency to another, submitting multiple applications until they find a program for which they are eligible.

Enlisting providers and community-based organizations to complete application forms on behalf of consumers

Through the state's "Virtual Gateway," trained and deputized staff of community-based organizations (CBOs) and health care providers can complete online application forms on behalf of individual consumers. The agencies become the consumers' authorized representatives, so they receive copies of state requests for additional documentation needed to establish eligibility. This allows them to educate consumers about applicable procedural requirements and ensure necessary follow-through.

Both before and after the 2006 reforms, the state has denied providers full reimbursement—including from the former UCP and the current HSN—when a patient does not satisfactorily complete an application for health coverage. As a result, safety-net hospitals and community health centers are motivated to devote significant staff resources to complete applications for patients through the Gateway and ensure satisfaction of procedural requirements through patient follow-up. In addition, CBOs have received "mini-grants," totaling \$2.5 to \$3.5 million a year from the state, plus additional amounts from foundations, to give these organizations the expertise and capacity to educate consumers in underserved communities and to help them enroll.

² Sullivan, Gregory W. 2007. Status Report Related to Health Care Reform Implementation Raised by the Joint Committee on Health Care Financing. Office of the Inspector General, The Commonwealth of Massachusetts. Boston, MA.

As a result of these combined factors (the Virtual Gateway, policies that encourage providers to complete applications for their patients, and mini-grants to CBOs to help people enroll), more than half of all successful Medicaid and CommCare applications since the 2006 reforms have come via the Virtual Gateway. *Between this system for application assistance and the above-described data-driven eligibility, most uninsured residents eligible for Medicaid or CommCare have had their eligibility determined without the consumers needing to fill out application forms.*

Public education (including information about the individual mandate)

Following the passage of reform legislation, Massachusetts carried out a massive public education campaign that informed state residents about new assistance and the individual mandate.^{3,4} Low-income people, who may not have understood that they were effectively exempt from the mandate, frequently worried about possible sanctions and therefore paid great attention to health coverage, which helped increase enrollment into Medicaid and CommCare.

Another result: Decreased administrative costs

The policies described above lowered the per capita administrative cost of determining eligibility and enrolling consumers into subsidized coverage, for several reasons. The state did not need to process new applications for people who qualified for CommCare based on data from the UCP; CBOs and providers carried out functions that other states perform using publicly funded social services staff; applications submitted by trained provider and CBO staff via the Virtual Gateway, which automatically warns about problems and requires corrections, had few errors and were therefore relatively inexpensive to process; and a single statewide office applied automated eligibility determination procedures and benefitted from economies of scale.

Many of the state's key administrative innovations were introduced years before the 2006 reforms. Policymakers planning to replicate similar approaches in other states or on a national level thus need to take into account the time required for successful implementation.

LIMITATIONS TO THE MASSACHUSETTS APPROACH

Despite the state's accomplishments, the enrollment strategies described above have limitations worth noting. First, between the state's unexpected success in reaching eligible residents and a greater need for assistance than officials anticipated, initial subsidy costs exceeded projected amounts (although later costs fell within the range of original estimates). Second, the state's eligibility system is not entirely integrated and data-driven, as illustrated by the following examples:

- The Medical Security Program (MSP), which subsidizes health coverage for laid-off workers with incomes below 400 percent of FPL, sits outside the state's integrated eligibility system and uses its own application forms and procedures. According to advocates, consumers can remain uninsured for months as they attempt to transition from the state's integrated eligibility system to MSP.
- Medicaid and CommCare have differing rules for eligibility periods. While Medicaid can end on any date, CommCare does not begin until the first day of a calendar month. As a result, if someone transitions from Medicaid to CommCare because of a mid-month change in household circumstances—for example, a new job or marriage—the person experiences a gap in coverage, which can last for several months if the Connector has to wait for the individual to select a plan or pay the first month's premium.

³ Anthony, Stephanie, Robert W. Siefert, and Jean C. Sullivan. 2009. The MassHealth Waiver: 2009-2011... and Beyond. Prepared by the Center for Health Law and Economics, University of Massachusetts Medical School, for the Massachusetts Medicaid Policy Institute and the Massachusetts Health Policy Forum. Boston, MA.

⁴ Commonwealth Connector. 2008. Report to the Massachusetts Legislature: Implementation of the Health Care Reform Law, Chapter 58, 2006-2008. Boston, MA.

- Coverage can easily end for procedural reasons when the time comes to renew eligibility, even for members who remain eligible. The renewal process lacks the user-friendly features that make initial enrollment easy for consumers, including intensive application assistance and data-driven eligibility. If members fail to complete and submit renewal paperwork, coverage ends. During an average quarter between October 2007 and December 2008, 47,433 consumers joined CommCare, but 37,771 members' coverage ended when renewal forms were required.^{5,6} Within five months of losing coverage, 21 percent of these members re-enrolled in the program.⁷

LESSONS FOR NATIONAL AND STATE POLICYMAKERS

Participation levels are much lower with most other state and federal subsidy programs than in Massachusetts. Examples of the former include Medicare Savings Programs, which cover less than a third of eligible seniors;⁸ CHIP, which, fully five years after the initial federal legislation passed, served only 60 percent of eligible children;⁹ and the Health Coverage Tax Credit, which reached between 12 and 15 percent of eligible laid-off workers and early retirees.¹⁰ However, by incorporating practices like those in Massachusetts, federal and state policymakers might avoid these problems and cover the vast majority of uninsured consumers who qualify for assistance.

Federal implications

To achieve the benefits of Massachusetts' data-driven eligibility system, federal reform legislation could base eligibility for an expanded Medicaid program, CHIP, and other subsidies on income tax information. Federal income tax returns, which are filed by more than six out of seven uninsured consumers,¹¹ could identify uninsured family members and help them qualify. Eligibility for Medicaid, CHIP, and other subsidies could be determined in each state by a single agency or multiple agencies working together behind the scenes. In either case, a single application form would be used for all programs, and a common methodology would determine eligibility. If national reform results in a single online application for all subsidy programs within each state, providers who have financial incentives to use that enrollment system for their uninsured patients, and funding for CBOs to furnish intensive, hands-on assistance, a large proportion of uninsured Americans who qualify for help are likely to receive coverage.

State implications

Enrollment practices in many states resemble those implemented in Massachusetts, but additional refinements may be needed to maximize participation while increasing the efficiency of eligibility determination.

Express Lane Eligibility (ELE), which is authorized by the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), permits states to use data from state income tax records and the files of other public benefit programs to grant eligibility for children's health coverage, notwithstanding differences between program methodologies for calculating income. For parents and other adults to benefit from ELE, states may be able to obtain Medicaid waivers under Section 1115 of the Social Security Act.

⁵ Authors' calculations from Boudreault 2008 and Commonwealth Connector 2009a:

Boudreault, Melissa. Commonwealth Care Quarterly Program Update: Board of Directors Meeting, Friday, October 17, 2008. Commonwealth Connector. Boston, MA.

⁶ Commonwealth Connector. 2009. Quarterly Update: January 15, 2009. Boston, MA.

⁷ Commonwealth Connector. 2009. Quarterly Update: April 9, 2009. Boston, MA.

⁸ Federman, Alex D., Bruce C. Vladeck, and Albert L. Siu. 2005. "Avoidance of Health Care Services Because of Cost: Impact of The Medicare Savings Program," *Health Affairs*, January/February; 24(1): 263-270.

⁹ Selden, Thomas M., Julie L. Hudson, and Jessica S. Banthin. 2004. "Tracking Changes in Eligibility And Coverage Among Children, 1996-2002," *Health Affairs*, September/October; 23(5):39-50.

¹⁰ Dorn, Stan. 2008. Health Coverage Tax Credits: A Small Program Offering Large Policy Lessons, prepared by the Urban Institute for the Robert Wood Johnson Foundation. Washington, DC.

¹¹ Dorn, Stan. 2009. Applying 21st-Century Eligibility and Enrollment Methods to National Health Care Reform. Prepared by the Urban Institute for the Pharmaceutical Researchers and Manufacturers of America. Washington, DC. (Publication pending)

Furthermore, using a single, integrated system to determine eligibility for Medicaid, CHIP, and other subsidy programs based on a single application form and statewide, automated processing could keep eligible consumers from falling through the cracks and losing coverage. Eligibility could be determined by the Medicaid agency, as in Massachusetts, or by multiple subsidy programs working together behind the scenes. Either way, a consumer would complete just one application to learn which program will provide coverage, without any need to file multiple forms with different agencies.

States could also train the staff of medical providers and community-based organizations (CBOs) to complete secure, on-line application forms for consumers. Consumers could appoint providers or CBOs to act as their representatives on eligibility matters, thus helping satisfy applicable procedural requirements. States could promote participation in such a system by funding CBOs and creating financial incentives for community health centers and hospitals to help uninsured patients complete applications. These practices could be required of providers for licensure, receipt of Disproportionate Share Hospital payments, or reimbursement from Medicaid and state employee health insurance.

Obviously, states can take different approaches to achieving coverage results like those realized in Massachusetts. However, the strategies applied by Massachusetts deserve serious consideration as potential models by states that seek either to reach large numbers of uninsured, eligible residents or to lower the operating costs of eligibility determination.

CONCLUSION

Innovative administrative strategies that were essential to the substantial reduction in the number of Massachusetts' uninsured are surprisingly unknown to health policy analysts outside the state. Through interviews with state policymakers and stakeholders, evaluators learned that most low-income uninsured consumers who enrolled in subsidized coverage did not need to fill out application forms. Instead, many qualified for assistance based on data already in the state's possession. Others had application forms completed by trained staff of safety-net providers or CBOs, using the state's online enrollment system. Even though the state sponsors multiple programs to subsidize health coverage and to reimburse providers for uncompensated care, a single state agency determines eligibility for almost all programs, based on a single, common application form. Massachusetts' innovative leveraging of information technology, extensive private-sector involvement in completing application forms, and centralized, statewide data processing have reduced operational administrative costs below the levels characteristic of traditional public benefit programs while preventing erroneous eligibility determinations and greatly increasing enrollment by uninsured residents who qualify for assistance. Finally, a major public education campaign gained consumers' attention by describing the subsidies and individual mandates included in the state's reform. Both at the federal level and in other states, similar measures may be needed for health reforms to achieve the fundamental goal of covering the low-income uninsured.

ABOUT THE SHARE INITIATIVE

SHARE is a national program of the Robert Wood Johnson Foundation and is located at the University of Minnesota's State Health Access Data Assistance Center (SHADAC).

The SHARE project has the following key goals:

1. Coordinate evaluations of state reform efforts in a way that establishes a body of evidence to inform state and national policy makers on the mechanisms required for successful health reform.
2. Identify and address gaps in research on state health reform activities from a state and national policy perspective.
3. Disseminate findings in a manner that is meaningful and user-friendly for state and national policy makers, state agencies, and researchers alike.

To accomplish these goals, SHARE has funded 16 projects covering 29 states.

CONTACTING SHARE

The State Health Access Reform Evaluation (SHARE) is a Robert Wood Johnson Foundation (RWJF) program that aims to provide evidence to state policy makers on specific mechanisms that contribute to successful state health reform efforts. The program operates out of the State Health Access Data Assistance Center (SHADAC), an RWJF-funded research center in the Division of Health Policy and Management, School of Public Health, University of Minnesota. Information is available at www.statereformevaluation.org.

State Health Access Data Assistance Center
2221 University Avenue, Suite 345
Minneapolis, MN 55414
Phone (612) 624-4802